BEFORE THE ARIZONA MEDICAL BOARD

SUSAN B. FLEMING, M.D. Holder of License No. 14840 for the Practice of Allopathic Medicine In the State of Arizona, Respondent.	**MD-06-0438A** **MD-07-0290A** **AMENDED CONSENT AGREEMENT FOR LETTER OF REPRIMAND AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and SUSAN B. FLEMING, M.D. ("Respondent"), holder of License No.14840 for the practice of allopathic medicine in the State of Arizona, the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement as set forth herein, and has had the opportunity to discuss this Consent Agreement with an attorney or has waived the opportunity to discuss this Consent Agreement with an attorney. Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding the expense and uncertainty of an administrative hearing.

2. Respondent understands that she has a right to a public administrative hearing concerning each and every allegation set forth in the above-captioned matter, at which administrative hearing she could present evidence and cross-examine witnesses. By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes all right to such an administrative hearing, as

well as all rights of rehearing, review, reconsideration, appeal, judicial review or any other administrative and/or judicial action, concerning the matters set forth herein. Respondent affirmatively agrees that this Consent Agreement shall be irrevocable.

3. Respondent agrees that the Board may adopt this Consent Agreement or any part of this agreement, under A.R.S. § 32-1451(F). Respondent understands that this Consent Agreement or any part of the agreement may be considered in any future disciplinary action against her.

4. Respondent understands that this Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. Respondent also understands that acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this state from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

5. All admissions made by Respondent in this Consent Agreement are made solely for the final disposition of this matter, and any related administrative proceedings or civil litigation involving the Board and Respondent. This Consent Agreement is not to be used for any other regulatory agency proceedings, or civil or criminal proceedings, whether in the State of Arizona or any other state or federal court, except related to the enforcement of the Consent Agreement itself.

6. Respondent acknowledges and agrees that, upon signing this Consent Agreement and returning this document to the Board's Executive Director, Respondent may not revoke his acceptance of the Consent Agreement or make any modifications to the document, regardless of whether the Consent Agreement has been issued by the Executive Director. Any modification to this original document is ineffective and void unless mutually approved by the parties in writing.

7. Respondent understands that the foregoing Consent Agreement shall not become effective unless and until adopted by the Board and signed by the Executive Director.

8. Respondent understands and agrees that if the Board does not adopt this Consent Agreement, she will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. Respondent understands that this Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and shall be reported as required by law to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

10. Respondent understands that any violation of this Consent Agreement constitutes unprofessional conduct pursuant to A.R.S. §32-1401 (27) (r) ([v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this

chapter) and may result in disciplinary action pursuant to A.R.S. § 32-1451.

11. **Respondent has read and understands the condition(s) of probation.**

ACCEPTED BY:

DATED: 5/8/08

Susan B. Fleming, M.D.

Attorney for Respondent

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 14840 for the practice of allopathic medicine in the State of Arizona.

MD-06-0438A

3. The Board initiated case number MD-06-0438A after receiving a complaint regarding Respondent's care and treatment of a forty-eight year-old male patient (CR).

4. On July 20, 2005, CR presented to Respondent with a three to four month history of upper back pain and "low grade" chronic low back pain that was periodically exacerbated by his lifting activities. Respondent performed a physical examination and prescribed #50 Oxycodone 5 mg q 4 hours prn pain. Respondent recommended myofascial release, therapeutic exercise, consultation with a surgeon regarding a possible inguinal hernia, and follow up in one month if needed.

5. Between August 2, 2005 and September 16, 2005, CR returned to Respondent's office five times requesting early Oxycodone refills. By September 16, 2005, Respondent was prescribing #300 Oxycodone 15 mg 1-2 q 4 hours for pain. After each visit Respondent scheduled CR for follow up in one month. Respondent performed a limited physical examination at each visit including completing a pre-printed questionnaire describing CR's development and nutrition.

6. On September 29, 2005 CR returned for an early follow up visit with Respondent stating that his planned hernia surgery was rescheduled and that he was "using a bit more pain medication" because he is working harder in anticipation of surgery. Respondent provided an early refill of #300 Oxycodone. Respondent refilled the prescription again on October 14, 2005 following CR's hernia surgery because CR had more pain than expected.

7. Respondent provided early refills of #300 Oxycodone 15 mg 1-2 q 4 hours prn pain four more times between November 1,2005 and January 3,2006.

8. At a January 19, 2006 visit, Respondent noted CR admitted to using more Oxycodone (12-15 tablets per day) than usual due to strenuous physical work. Respondent performed a limited physical examination and noted CR to be "stable on medications." Respondent also noted that CR's use of opioids would not be short term and requested CR sign an opioid agreement. An early refill of Oxycodone was provided.

9. At a January 27, 2006 office visit, CR reported that he had been involved in a motor vehicle accident on January 23, 2006. Respondent

documented his recent history and her examination. Later that day, CR reported by telephone that his medications had been stolen. Respondent provided a prescription for an early refill of Oxycodone on February 2, 2006, when CR was in the office for physical therapy.

10. On February 17, 2006, Respondent's office received a telephone call from a pharmacy expressing the pharmacist's concerns that CR filled his Oxycodone prescriptions every 17-18 days, indicating that he was not following his prescription directions. Respondent gave her office staff instructions to inform the pharmacy not to fill the prescription and to have the pharmacist "make him [CR] follow the directions."

11. CR returned to Respondent's office on March 10, 2006 complaining of pain from a broken tooth and dental infection and stated the dentist was currently unavailable. Respondent provided an Oxycodone refill and recommended CR return in one month for follow up. CR returned on March 30, 2006 and Respondent noted he used "a bit more Oxycodone" than usual following dental extraction. Respondent provided a seventeen day supply of Oxycodone and recommended CR return in one month. CR returned on April 19, 2006 and Respondent noted he was using Oxycodone as needed for ongoing dental work. Respondent noted CR was "stable on current medications." Oxycodone was refilled.

12. On May 9, 2006, CR was seen by Respondent's medical assistant (MA). MA noted CR reported to have run out of medications on Saturday, but

there was no reason for his early depletion of medications. MA scheduled CR for a urine drug screen on his next visit. Respondent reviewed the history, physical and plan of care for CR.

13. On May 25, 2006, Respondent confronted CR about a message from CR's sister concerning his opioid usage. CR stated he "is using a lot more medication and is not happy with the situation." Respondent planned to wean CR of his medications and prescribed #100 Oxycodone 15 mg with instructions to take only 10 Oxycodone per day. Respondent also prescribed #90 Lorazepam 1.0 mg tid to help with withdrawal symptoms. Respondent did not document her instructions to CR regarding the addition of Lorazepam. Respondent did not perform and made no mention of the urine drug screen that was planned for this visit, but did advise CR that no further early refills would be provided. That day, CR was admitted to the hospital emergency room after he was involved in an automobile accident with his mother and six year old child as passengers. CR informed hospital staff he filled his prescriptions for Oxycodone and Lorazepam that day. CR admitted to taking two Oxycodone and four Lorazepam tablets. However, the emergency room physician noted thirteen Oxycontin and four Lorazepam tablets were missing from their containers. CR was overheard making homicidal threats to his mother and was determined to be a danger to others and required hospitalization. The emergency room physician copied Respondent on his dictated report, but Respondent stated she did not receive it.

14. CR was discharged from the hospital on May 30, 2006. During his

hospitalization, he reported that "he may have been using his medications more than prescribed" and admitted to impulsive behavior in taking his medications. CR's urine drug screen was positive for opiates, cannabinoids, and tricyclics. He was diagnosed with polysubstance abuse and untreated depression.

15. On June 1, 2006, CR returned for a follow up visit with Respondent and reported to have reduced his Oxycodone use to ten tablets per day. Respondent did not document a physical examination and recommended follow up in two weeks.

16. Respondent was not aware that CR had been hospitalized in May 2006 until she received notice from the Board on June 8, 2006 of a complaint filed against her by CR's sister.

17. CR returned to Respondent's office on June 15, 2006. Respondent noted CR had been taking eight tablets of Oxycodone per day and provided him with a prescription for #50 Oxycodone 15 mg with instructions to take only six per day. At this visit, CR informed Respondent he took a mild overdose of Lorazepam and was hospitalized. Respondent obtained a release in order to obtain the hospital records. On June 22, 2006, after receiving the hospital records and determining CR had not been truthful regarding the hospitalization, Respondent informed CR she would no longer prescribe opiates to him.

18. The standard of care requires a physician to adequately perform an examination and evaluation of a patient prior to prescribing medications. The standard of care requires a physician to properly prescribe medications, closely

8168

monitor for, recognize and follow up on problems suggestive of non-compliance and/or aberrant drug seeking behavior when prescribing long term opioids for chronic pain. The standard of care also requires a physician monitoring a patient's chronic pain to coordinate care with other treating physicians so as not to manage acute postoperative pain without the knowledge of and/or the express consent of the treating physicians.

19. Respondent deviated from the standard of care by failing to perform an adequate physical examination and evaluation on CR prior to prescribing Oxycodone refills in the setting of early refills and red flags for possible substance abuse. Respondent's examination included completing a pre-printed questionnaire describing CR's development and nutrition. Respondent deviated from the standard of care by failing to properly prescribe Oxycodone for minor injuries and for failing to recognize and follow up on problems suggestive of substance abuse and violations of an opioid agreement occurring between August 2005 and June 2006. Respondent also deviated from the standard of care by approving and providing CR with Oxycodone to treat post-extraction dental pain and pre- and post-operative hernia discomfort without informing the physicians treating CR for these conditions and/or without their express consent.

20. Respondent's inappropriate prescribing perpetuated CR's inappropriate drug seeking behavior and addiction.

MD-07-0290A

21. The Board initiated case number MD-07-0290A after receiving a complaint from a 41 year-old patient JS against another physician. After a review of Respondent's records Board staff raised concerns about Respondent's treatment of JS relating to her care for chronic pain.

22. Respondent treated JS for chronic pain involving headaches and musculoskeletal pain. For four years Respondent prescribed controlled substances to JS and increased the dosages without clear reasons.

23. JS established care with Respondent on June 16, 1999 as a self-referred patient. He was 37 years old at the time. JS reported that he had undergone several MRI and CT scans and seen multiple physicians including for pain management. His current medications were listed as Dilaudid 4 mg, MS Contin 60 mg and Valium 10 mg, but no dosing intervals or frequency are given. He was also prescribed Baclofen 10 mg tid.

24. Respondent performed an examination and diagnosed low back pain, lumbar radiculitis and muscle spasm. She noted in her records "Get MRI report." She recommended physical therapy and medication management, with follow up in one month. She wrote prescriptions for Dilaudid 4 mg #100 one half to one tablet q four hours prn breakthrough and MS Contin 60 mg bid.

25. Over the next four years, Respondent continues to provide regular prescription refills for Dilaudid, MS Contin and Valium, often without having JS into the office for evaluation. Sometimes the prescriptions were pre-dated and

frequently the refill prescriptions were provided early. The prescription for MS Contin, originally at 120 mg daily dosage, was reduced to 60 mg in July 1999 and then increased to 90 mg daily in June 2000. Dilaudid 4mg was initially prescribed in a quantity of 100 per month throughout 2000. In 2001, the quantity was increased to 200 per month. These MS Contin daily doses and Dilaudid monthly quantities do not reflect the early refills providied.

26. In July 2001, Respondent prescribed Zoloft for depression and Neurontin. Respondent's records continue to reflect a pattern of increasing opioid dosages (MS Contin increased to 150 mg daily in December 2002 and then to 270 mg daily in May 2003) and increasing frequency of early refills, including exhaustion of a one month supply of both MS Contin and Dilaudid in one week. Early refills are often provided without any office visits for evaluation of noncompliance and escalating opioid requirement.

27. Respondent's records do not include any records obtained from other healthcare providers including none of the prior MRI or CT scans.

28. The standard of care requires a physician to obtain previous medical records and imaging reports, verify current prescriptions, and/or contact the previous treating physician. The validity of the prior prescriptions and the reason for leaving the care of the prescribing physician need to be fully investigated. The standard of care requires that the physician identify an appropriate medical rationale for prescribing opioids long term.

29. Respondent deviated from the standard when she did not obtain prior medical records or imaging reports. The mode of injury provided by JS was unusual for continued pain requiring opioid management five years later. Respondent did not pursue past medical record review and/or further work up to identify an objective pain generator to justify ongoing opioid management.

30. The standard of care requires a physician providing long-term opioids for chronic non-malignant pain to closely monitor for, recognize and follow up on problems suggestive of aberrant drug-related disorders.

31. Respondent failed to recognize that self-referral may be a red-flag for potential "doctor shopping" particularly when a patient reports that they are currently prescribed opioids for chronic pain by another provider. She failed to investigate or establish the validity of the prior prescriptions and the reason for leaving the care of the most recent prescribing physician. Respondent failed to recognize aberrant drug seeking in the form of the noncompliance and repeated early refills of both sustained release and short acting opioids between 1999 and June 2003. Repeated early depletion of escalating doses of short acting opioid (Dilaudid) was not addressed by Respondent. She perpetuated JS's drug seeking by inattention to her own prescribing habits and by prescribing early refills upon telephonic demand in the absence of office visits or adequate medical rationale. She failed to adequately address and monitor what JS reported to be a problem with misuse of Valium and instead allowed eighteen prescriptions for 100 Valium 10 mg over less than a five month interval.

32. The standard of care requires that escalating opiod requirement is considered a new finding and should be worked up appropriately to identify or rule out disease progression or new injury.

33. Respondent deviated from the standard of care by providing substantial dose escalation of MS Contin and Dilaudid without adequate workup or rationale and failed to recognize signs of non-compliance and possible substance abuse or diversion.

34. When renewing prescriptions for controlled substances, the standard of care requires a physician to be aware of the disposition of previously allowed refills.

35. Respondent deviated from the standard of care when in January 2003 she provided two prescriptions for 100 Valium 10 mg each with five refills and in May 2003 she provided a third prescription for 100 Valium 10 mg with five refills.

36. Respondent provided JS with post dated prescriptions on two occasions in violation of the Arizona statutes.

37. The standard of care requires that when acute psychosocial stressors have significantly worsened the subjective pain experience, severely impaired coping skills, and/or triggered symptoms of post traumatic stress disorder, appropriate referrals for counseling, behavioral and cognitive therapy are indicated. It is inappropriate to treat these conditions with substantial opioid dose escalation in the absence of disease progression or a new pain generator.

38. Respondent deviated from the standard of care by inappropriately treating increased stress with substantial opioid dose escalation in the absence of disease progression or a new pain generator, and by failing to obtain appropriate mental health care referral.

39. JS was harmed by this conduct as it allowed for perpetuation of inappropriate drug seeking behavior. JS was at an increased risk of harm for substance abuse, inadvertent or purposeful drug overdose and toxicity, respiratory depression, seizure, aspiration pneumonia, neurological damage, and death from inappropriate prescribing of controlled substances.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Susan B. Fleming, M.D., (Respondent), holder of license number 14840, for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(q) - "Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public," and A.R.S. §32-1401(27)(ll) - "Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(k) – "Signing a blank, undated or predated prescription form."

ORDER

IT IS HEREBY ORDERED that:

1. Respondent, Susan B. Fleming, M.D., License Number 14840 be issued a Letter of Reprimand for improper prescribing, inadequate examination and evaluation of the patient, prescribing in excess of findings reported and failure to recognize or deal with evidence of narcotics abuse on several occasions.

2. Further, Respondent is placed on probation for **one year** with the following terms and conditions:

a. Continuing Medical Education

Respondent shall within **one year** of the effective date of this Order obtain twenty hours of Board Staff, pre-approved Category I Continuing Medical Education (CME) in appropriate evaluation and treatment of chronic pain patients and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license and in addition to hours obtained under the previous Order. The probation shall terminate upon successful completion of the CME.

b. Chart Review

Board staff shall conduct a random review of Respondent's patient records within six months of the effective date of this Order.

///

c. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court order, criminal probation, payments and other orders.

d. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice with Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. This Order is the final disposition of cases number MD-06-0438A and MD-07- 0290A and replaces the original agreement entered April 13, 2007.

DATED AND EFFECTIVE this 1st day of August 2008.

ARIZONA MEDICAL BOARD

(SEAL)

By: Lisa Wynn
Executive Director

///

Original of the foregoing filed
this 12th day of Aug, 2008 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road

Executed copy of the foregoing mailed
this 12th day of Aug, 2008 to:

Stephen W. Myers, Esq.
Myers & Jenkins, PC
3003 North Central Avenue, Ste. 1900
Phoenix Arizona 85012

Executed copy of the foregoing mailed U.S.
Certified Mail this 12th day of Aug, 2008 to:
Susan B. Fleming, M.D.
Address of Record

Investigational Review

doc #145469